



Title	Policy for Adult Male and Female Urinary Catheterisation
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Contents

1.	INTRODUCTION	3
	Obstetrics & Gynaecology	3
2.	COMPETENCE AND TRAINING	4
3.	CATHETER PASSPORT	5
4.	CATHETERISATIONS.....	7
5.	HOSPITAL URINARY CATHETER MANAGEMENT	17
6.	COMMUNITY URINARY CATHETER MANAGEMENT	17
7.	CATHETER MAINTENANCE SOLUTIONS	18
8.	MALE ACUTE RETENTION OF URINE.....	19
9.	INFECTION.....	19
10.	NURSE LED CATHETER REMOVAL.....	21
11.	TRIAL WITHOUT CATHETER (TWOC)	22
	APPENDIX 1 - PROTOCOL FOR MALES PRESENTING WITH ACUTE RETENTION OF URINE.....	26
	APPENDIX 2 – 5 MOMENTS FOR HAND HYGIENE – CARING FOR A PATIENT WITH A URINARY CATHETER	27

1. Introduction

This is the NHS Borders Adult Male and Female Urinary Catheter Policy.

Deviation from this policy must be supported by a Standard Operating Procedure (SOP) signed off by the Prevention of Catheter Associated Urinary Tract Infection (CAUTI) Group.

Statement of Intent

The aim of this Policy is to provide guidance to support:

- reduction in CAUTI
- improvement in urinary catheter management
- reduction in the numbers of urinary catheters in use in NHS Borders
- reduction in urinary catheter related mortality and morbidity.

Objectives

- standardise practice across NHS Borders
- minimise potential risk of infection associated with urinary catheters
- ensure that all staff undertaking this procedure are competent in insertion of urinary catheters and their management
- ensure that catheters are removed appropriately at the earliest possible point
- ensure alternatives to urinary catheterisation are fully considered prior to catheterisation
- ensure that patients are aware and informed of the risks of an indwelling urinary catheter
- engage patients in the management of their catheter.

Procedure

All staff carrying out procedures guided by this policy will follow those laid down in the [Royal Marsden Manual](#)

Obstetrics & Gynaecology

Obstetrics and Gynaecology patients should be managed in accordance with the Obstetrics & Gynaecology unit policies.

This policy should be read in conjunction with specific guidance for Urinary catheterisation in Obstetrics and Gynaecology patients, for example: [Postpartum Bladder Scanning by Trained Midwife Practitioners](#), or *bladder catheterisation and post-operative catheter management procedures for Gynaecological patients*. Further exceptions include, but are not limited to, residual bladder volume.

Key changes to practice in NHS Borders

1. Requirement for training and clinical update - page 4
2. Use of 'Patient Held Urinary Catheter Passport' - page 5
3. Use of nurse led catheter removal for in-patients - page 21

Health Care Professional Responsibility is to:

- obtain, maintain and improve their professional knowledge and competence
- undertake appropriate training and are competent to perform urinary catheterisation
- read and adhere to this policy
- ensure that the patients care plan actively promotes their privacy and dignity and protects their modesty
- be aware of current research evidence regarding catheter care
- catheter changes and care should be documented in the NHS Borders Catheter Care Passport
- ensure the patient is assessed and that the procedure is appropriate care for the individual before it takes place.

2. Competence and Training

Criteria for performing the role

- Registered Health Care Professionals who have been trained and supervised
- Must be able to demonstrate theoretical and practical competence appropriate to the particular individual need of their patients. Instruct patients and their carers in the technique.

NB. Training needs will be addressed in liaison between the Health Care Professional and the line manager.

All NHS Borders staff involved in urinary catheterisation should undertake the Urinary Catheterisation or Clinical Update *learnPro* module.

- This includes Non-registered staff who have undergone the relevant instruction in male and female urinary catheterisation commensurate with their role
- All new staff to NHS Borders undertaking urinary catheterisation should consider completion of the full Urinary Catheterisation *learnPro* module (In order to demonstrate competence), as part of their PDP, or demonstrate competence in transferrable skills
- Clinical Update *learnPro* module or equivalent should be completed approximately 3 yearly, in order to demonstrate competence. This is a short 10-15 minute on-line update

- As part of KSF, annual review to be completed by manager demonstrating appropriate level of skill, competence and knowledge:
 - a. the indications for catheterisation
 - b. the different types of catheter available
 - c. different charriere sizes of catheters which may be available
 - d. differing drainage systems
 - e. aseptic technique required
 - f. the causes of catheter acquired urinary tract infection
 - g. complications of catheterisation

Bladder scanner training may be accessed via the Urology Specialist Nurses

Consent

Informed consent must always be obtained in accordance with national and local guidelines. Any issues regarding capacity to consent must be documented in the patient's medical/nursing records. Please refer to [NMC Code of Conduct](#). Please refer to [Adults with Incapacity \(Scotland\) Act 2000](#) (a short guide to the act).

3. Catheter Passport

All patients with an indwelling urethral or suprapubic catheter must have an NHS Borders Catheter Care Passport completed.

This is a patient held document which will remain with the patient throughout their catheter journey in Primary, Secondary or Tertiary Care.

The Catheter Passport is filed in the medical records when no longer required.

- all medical sections of the Catheter Passport must be completed by the Health Professional
- initial insertion or complicated insertions must be noted, along with advice for either future hospital or community re-insertion
- the passport must be explained to the patient and or carer
- discuss the risk of infection and importance of basic hygiene, care and early removal
- daily care should be documented. The patient should be encouraged to undertake and complete this themselves
- carers must be encouraged to complete the passport where they are undertaking daily care
- specific care needs, comments and problems should be documented
- trial without catheter must be documented in the appropriate section.

The clinician responsible for the care of the patient must review the ongoing need for the urinary catheter at regular intervals according to clinical need of the patient.

Aid for decisions

1. The decision to catheterise should be made following a full holistic assessment, with due consideration given to alternative methods of management. **Clinicians must remember that there are significant risks associated with catheter usage requiring robust decision making.**
2. Never catheterise or continue catheter usage for nursing convenience.
3. Routine catheterisation must not be supported, particularly in specific patient groups such as fractured neck of femur.
4. Incontinence is not an indication for catheterisation, and treatment for underlying medical conditions must be excluded. Decision to catheterise should be made as part of a multidisciplinary team discussion.
5. Treatment for medical conditions causing incontinence must be excluded. There must be no significant residual urine volume.
6. For male patients non-urinary devices such as sheaths are the first line of action, (where obstruction has been excluded). Where they do not prove to be effective, size or fit and or alternative products must be considered.
7. Catheterisation can increase the risk of pressure ulcer development, as there is a tendency to reduce patient interactions such as toileting and pad changes.
8. Where chronic wounds are present, catheterisation presents greater risk due to their colonisation with multi-resistant bacteria and the likely risk of cross infection to the urinary tract.
9. Clinician must ensure that catheterisation is based on a balanced decision.
10. Catheterisation of patients who are agitated or cognitively impaired is best avoided where possible.
11. Never totally base the decision to catheterise on residual urine status even if the amount is considerable. Where a residual volume of urine is identified, the patient's symptom and severity profile along with their renal function and cognitive status must be considered prior to catheterisation.
12. Clinicians should consider early removal as the infection risk increases on a daily basis.

Use of antibiotics

Almost all patients with a long term indwelling catheter will develop bacteriuria without symptoms of UTI.

Routine antibiotic therapy for patients with bacteriuria is not recommended unless the patient has symptoms of a urinary tract infection.

4. Catheterisations

	Urethral Catheterisation	Suprapubic Catheterisation	Intermittent Catheterisation
Advantages		<ol style="list-style-type: none"> 1. There is no risk of urethral trauma, necrosis, or catheter-induced urethritis. 2. There is greater comfort, particularly for patients who are chair bound. 3. Access to the entry site is easier for cleansing and catheter change. 4. There is greater expression of sexuality. 	<ol style="list-style-type: none"> 1. Effective way of managing patients with voiding difficulties 2. Reduces the risk of common indwelling catheter associated problems 3. Protects the upper urinary tract from reflux 4. Provides greater freedom for expression of sexuality 5. Improves the patient's potential for self-care and independence 6. Reduces the need for equipment and appliances.
NB:	<p>When changing a urethral catheter or supra pubic catheter, passive deflation of the catheter balloon is recommended, this causes less cuffing of the catheter balloon and less trauma for the patient. (Syringe attached to catheter balloon and allowed to deflate itself).</p>		

	Urethral Catheterisation	Suprapubic Catheterisation	Intermittent Catheterisation
Indications	<ul style="list-style-type: none"> • surgical procedures during and following abdominal, gynaecological or urological surgery • acute urinary retention (refer to Appendix 1) • chronic urinary retention with renal impairment • debilitating disease involving skin ulceration • severe burns • allow monitoring of fluid balance in a severely ill patient • introduce Intravesical drug therapies • clinical investigations severe mobility problems, disability, unfit for surgery • ensure comfort and dignity in end of life care. 	<ul style="list-style-type: none"> • following elective abdominal or urological surgery • acute urinary retention, when urethral access not possible • chronic retention with renal impairment. When urethral access not possible • advanced neurological disease requiring long-term catheter for incontinence • disorders of the genitalia or urethral trauma. • anatomically difficult to urethrally catheterise • patient preference, particularly if sexually active or to maintain ability to self care • patients with surgical or acquired urethral closure • unable/ unwilling to perform intermittent self-catheterisation • persistent expulsion of urinary catheter mobility problems, where other options have failed • incurable incontinence, where other options have failed • minimise urethral trauma in long term catheterised patients. 	<ul style="list-style-type: none"> • management of chronic urinary retention or incomplete bladder emptying • male or female patients who suffer from some form of neurogenic bladder dysfunction or voiding difficulty • management of a urinary pouch via a continent stoma • measurement of residual urine (if a Bladder scanner is not available) <p>instillation of drug therapy stricture therapy.</p>

	Urethral Catheterisation	Suprapubic Catheterisation	Intermittent Catheterisation
Contraindications	<ul style="list-style-type: none"> • pelvic fracture • severe burns • failed Trial Without Catheter (TWOC) within 7 days of Transurethral Resection of the Prostate (TURP) • femoral-femoral crossover vascular grafts • artificial urinary sphincter. • Suspected or known abdominal mass is not a contra-indication for non-medical catheterisation. A single attempt at catheterisation should be made in the first instance based on clinical risk assessment. 	<ul style="list-style-type: none"> • there is a known or suspected carcinoma of the bladder • undiagnosed haematuria • previous lower abdominal surgery • blood clotting disorders • ascites • suspected/diagnosed ovarian cyst • severe obesity. <p>Cautions</p> <ul style="list-style-type: none"> • cognitive impairment. • 	
Indications for hospitalisation for insertion/change	<ul style="list-style-type: none"> • fresh haematuria • within 3 weeks of radical prostatectomy or bladder reconstructive surgery. Consult Urology Department if re-catheterisation is required • Urethral Obstruction 		

	Urethral Catheterisation	Suprapubic Catheterisation	Intermittent Catheterisation
Basic principles	<ul style="list-style-type: none"> • selection of the catheter material must be based on research evidence and individual needs • balloon size of 10mls must be used • it is advisable patients to have a spare catheter at home; so that replacement can occur as quickly as possible should the old catheter fall out • in patients for whom it is appropriate, a catheter valve may be used as an alternative to a drainage bag. However, catheter valves should not be used for patients with renal impairment without medical discussion • Suprapubic Catheters ONLY - length of catheter used is mostly dependant on patient preference. Standard length is 1st choice but female length is acceptable where indicated 		
Catheter Selection	<p>It is important to choose the correct catheter for the individual patient e.g. make, type, length, CH/FG size and balloon infill volume.</p> <p>Note in NHS Borders Secondary Care: a standard length catheter is the one of choice for all patients.</p> <p>The differing types of catheter and their suitability are part of the catheterisation module</p> <p>Clinicians should refer to NHS Borders Joint Prescribing Formulary for most appropriate urinary catheter prescription.</p>	<p>Refer to NHS Borders Joint Prescribing Formulary for <u>suprapubic</u> catheter selection.</p> <p>The size must be maintained upon catheter change, unless otherwise clinically indicated.</p> <p>Initial Catheterisation</p> <p>The first insertion of a suprapubic catheter must always be undertaken by a clinician competent in this procedure in a hospital theatre environment, under a general or local anaesthetic.</p>	<p>"Intermittent Self Catheterisation" (ISC) The patient intermittently passes a catheter into the bladder to assist in the drainage of urine where normal voiding is not possible. This is a clinically clean procedure.</p> <p>Re-Usable Catheters</p> <p>In NHS Borders 'once only' catheters are used for ISC. These are non balloon catheters made of plain nelaton or a coated nelaton (hydrophilic). The NHS Borders Joint Prescribing Formulary will list the catheters recommended for NHS Borders.</p>

	Urethral Catheterisation	Suprapubic Catheterisation	Intermittent Catheterisation
	<p>In Primary Care a female length catheter may be ordered for a female patient on a named patient basis.</p> <p>Smaller gauge catheters minimise the risk of urinary trauma and residual urine volumes, which predispose to Urinary Tract Infections. (12-14fg catheter is normally suitable for men and women) (Robinson, 2006).</p> <p>In the event of persistent balloon expulsion please seek advice from The Department of Urology, BGH.</p> <p>The normal balloon size is 10mls. Clinical advice should be sought before using a larger balloon.</p> <p>There is a need to consider the possibility of latex allergy, which would contra-indicate the use of Hydrogel coated latex catheters and necessitate the use of all-silicone catheters.</p>	<p>Size 16 - 18ch catheter is generally inserted at the initial insertion, although a size 20-22 may be used in patients with a neuropathic bladder.</p> <p>When changing the initial suprapubic catheter, it may be switched to an all silicon catheter, size 16ch or 18ch following initial insertion.</p> <p>Once the abdominal channel has become established (after 4 weeks) a suprapubic catheter can be changed routinely by a registered Health Care Professional who has undergone and achieved competences in line with NHS Borders training requirements. If the same CH size cannot be inserted please discuss with the urology department immediately.</p> <p>Ongoing re-catheterisation A suprapubic catheter should be replaced within half an hour of the removal of the existing catheter.</p>	<p>II. "Intermittent Catheterisation" by the relative or carer who intermittently catheterises the patient to assist in the drainage of urine where normal voiding is not possible. This is a clinically clean procedure. In this instance training in the technique of intermittent catheterisation must be given by an experienced professional together with instruction on correct hand-washing techniques.</p> <p>III. "Intermittent catheterisation of urine" by medical professionals. This is usually performed in an acute or emergency situation to relieve urinary retention prior to the future management of the patient's bladder problem being decided.</p>

	Urethral Catheterisation	Suprapubic Catheterisation	Intermittent Catheterisation
			<p>In this instance catheterisation must always be carried out with a sterile technique. This should not continue as a form of long-term management and full clinical assessment and investigation must be undertaken.</p> <p>Frequency of Intermittent catheterisation episodes</p> <ul style="list-style-type: none"> • dependent upon individual patient needs and based on full clinical assessment • comprehensive fluid chart maintained for the initial 2 weeks to ensure that care plan is safe and correct <p>Stricture programmes differ with each individual. Always check with the Urologist.</p>
Lubricant	Anaesthetic based gel must be used prior to catheterisation for both male and female patients as per manufacturer's instructions.		

	Urethral Catheterisation	Suprapubic Catheterisation	Intermittent Catheterisation
Changing urinary drainage systems	<p>A catheter valve may be fitted instead of a drainage bag. However a valve should not be used if there is a known hydronephrosis or there is a history of cognitive problems.</p> <p>Leg bags or catheter valves must be changed every seven days as per manufacturer's guidelines. Urinary catheters should be connected to a sterile closed drainage system incorporating a link system for overnight drainage to keep the day system intact.</p> <p>Ensure patient/ carer uses a new 2 litre non drainable night bag every 24 hours. Maintaining a closed system is vital to reduce risk of infection.</p> <p>Ensure patient and carer are taught to change leg drainage bags using a clean technique.</p>		
Emptying urine bag or catheter valve	<p>Ensure patient/ carer has access to suitable container and are aware of how to keep it clean and dry when not in use. Clean with alcohol wipe after drainage.</p>		

	Urethral Catheterisation	Suprapubic Catheterisation	Intermittent Catheterisation
Catheter Specimens of Urine (CSU)	<p>Change catheter immediately and obtain urine sample from the new catheter sampling port using aseptic technique. (NICE Guidelines 2003). Follow Royal Marsden Procedure and clean port with 2% chlorhexidine in 70% isopropyl (Blue Clinell wipe).</p> <p>Laboratory microscopy and Dip stick (urinalysis) testing must not be used to diagnose UTI in catheterised patients.</p>		
Securing Catheter	<p>All urinary catheters, whether short term or long term, should be supported with a catheter retaining strap (G strap) to minimise trauma at bladder neck and external meatus. This is in addition to securing device, as well as the catheter bag straps.</p> <p>The leg bag strap is not a catheter retaining strap. A catheter retraining strap is required in addition to the leg bag strap.</p> <p>Catheterised patients who are mobile should be fitted with a well supported leg bag.</p> <p>Product details are available in the NHS Borders Joint Prescribing Formulary.</p>	<p>It is advised that suprapubic catheters are secured by a suitable device to prevent tension to the catheter and site.</p>	

	Urethral Catheterisation	Suprapubic Catheterisation	Intermittent Catheterisation
Bag position and support	<p>The Health Care Professional must ensure that patient/ carer understands the need to keep the urine bag below the level of the bladder.</p> <p>Ensure that the leg drainage bag is secured using either leg straps or sleeve. Do not use these straps to secure catheter.</p> <p>Ensure leg bag is drained every 3-4 hours or when 2/3 full whichever is soonest.</p> <p>Ensure patient/ carer understand the need to 2 litre non drainable night bag for use over night, ensuring that a catheter stand is used to support the bag. Clean leg bag connection with alcohol wipe or detergent solution.</p> <p>The bottom of the urine bag should be suspended above floor level at all times.</p>		
Immobile Acute Patients	<p>Should have a standard drainable urine bag attached to the hospital bed. (A disposable stand should be used where the bed hook is not accessible) The patient's bed should be lowered to the lowest possible height to enable the catheter bag to be free from the floor. Where there is a requirement to lower the bed further a catheter stand should be used.</p>		
Patient discharge from hospital	<p>The hospital is responsible for notification of a patient being discharged with a urinary catheter to the district nurse and GP.</p> <p>Before leaving hospital, patients should be shown how to look after their catheter and drainage system.</p> <p>ONLY Intermittent Catheterisation - ensure the patient understands how to order their supply of catheters.</p> <p>All catheterised patients must have a NHS Borders Catheter Care Passport commenced on initial catheter insertion.</p> <p>Patients are to be discharged with one week's supply of leg bags/catheter valve, night bags, x1replacment catheter, x1 catheter stand and information booklet.</p> <p>Subsequent catheters are obtained on prescription via the GP</p>		

	Urethral Catheterisation	Suprapubic Catheterisation	Intermittent Catheterisation
Responsibility of the Health Care Professional	<ul style="list-style-type: none"> • once regime is established, review must be at least twice per year. Telephone/ postal review is acceptable provided there is a medically agreed protocol • no signs and symptoms of infection prior to initial instruction • no frank haematuria prior to initial instruction • if the patient is on chemotherapy and is immunosuppressed seek medical advice • in the event of a pregnancy discuss with the obstetrician • if obstructed on insertion, haematuria present, or infection suspected medical advice should be sought as soon as possible. 		
Non-registered nurse urinary catheter insertion	Non-registered staff may only undertake urinary catheterisation following formal training and specific departmental agreement. The registered Health Care Professional responsible for the patient remains accountable for all non-registered staff practice.		
Documentation	The Health Care Professional undertaking catheterisation must document all details of the catheterisation within the patients' NHS Borders Catheter Care Passport in accordance with the NMC Standards for Records and Record Keeping and give to the patient/carer on discharge.		

There is no policy or legal position regarding or male practitioners catheterising female patients or female practitioners catheterising male patients. Patients should be offered a chaperone or be invited to request the presence of a chaperone. Nurses and other health care professionals should consider being accompanied by a chaperone (irrespective of organisational constraints or settings in which this is carried out) when undertaking intimate examinations and procedures to avoid misunderstanding and, in rare cases, false accusations of abuse (RCN 2006)

5. Hospital Urinary Catheter Management

The senior charge nurse is responsible for the process of urinary catheter management on their wards and adherence to this policy by all staff.

They must ensure that all staff:

- are competent and trained
- use and provide patients with a urinary catheter passport
- have systems in place to ensure early urinary catheter review and removal
- avoid ALL unnecessary urinary catheter insertions.

On discharge from BGH the patient will be provided with a catheter discharge pack which includes:

- 5 single use night bags
- 1 leg bag with straps
- Patient information booklet on catheters

The ward nurse will supply spare catheter to the pack with the appropriate sized catheter.

All patients must be given a NHS Borders Catheter Care Passport unless on a specified and agreed post operative pathway.

Changing catheter bags in a hospital setting should be conducted as a sterile procedure with sterile field and gloves.

Night bags should be changed using a clean procedure (clean leg bag connection with alcohol wipe or detergent solution) and must always be single use disposable items regardless of manufacturers instructions.

6. Community Urinary Catheter Management

District nursing teams must be informed prior to hospital discharge of any patients coming home with a urinary catheter in place.

A member of the District Nursing team will contact the patient within 48 hours of discharge to arrange the home visit assessment and continue to maintain the NHS Borders Catheter Care Passport.

Note: Some patients may be seen in health centre rather than at home.

The District Nursing team will be responsible for ensuring the patient has:

- a continued supply of urinary drainage systems and securing devices in accordance with [NHS Borders Joint Prescribing Formulary](#)

- a supply of sterile urinary catheters and *Instillagel* in accordance with NHS Borders Prescribing Formulary
- a supply of sterile catheter packs and gloves for routine and unplanned catheter changes
- a supply of catheter maintenance solutions (if required) and prescription sheet.

It is preferable that catheter bags are changed using a sterile procedure as it breaks the 'closed system', however, a clean 'non-touch' procedure is appropriate. The connection should be cleaned with 2% chlorhexidine in 70% isopropyl (blue clinell wipe) before disconnection.

If a patient is admitted to hospital, the District Nursing team should endeavour to ensure the patient has their catheter passport with them.

The District Nurse will liaise with home care providers within 48 hours as appropriate to ensure catheter hygiene is maintained when patient is dependent on home carers.

The District Nurse will become the clinician responsible for the ongoing management of the patients Urinary Catheter, (where specialist management, is required this will be documented in catheter passport and told prior to discharge).

The District Nurse will assess the ongoing need for a urinary catheter on admission to case load and prior to each catheter change and if appropriate arrange for Trial with out Catheter (as per NHS Borders policy). Liaising with the Urology Nurse Specialist and or the Continence Service if appropriate or required.

All District Nurses will be competent in assessing individual patients to ensure urinary catheter is the appropriate intervention.

7. Catheter maintenance solutions

Catheter Maintenance Solution is a prescription-only medication. Instilling Catheter Maintenance Solutions break the closed drainage system. **Only perform if evidence of encrustation and following discussion with Urology Nurse Specialist. Do not use solutions for any other management.**

Do not use solutions to unblock catheters, blocked catheters should always be removed and replaced.

Any catheter maintenance regime should be undertaken as infrequently as possible in order to achieve clinical improvement.

Individuals with a pH above 6.8 are more likely to experience problems with an encrusted catheter.

Refer to catheter maintenance section in Urinary Catheter Care Passport for details of PH management of encrusted catheters.

8. Male Acute Retention of Urine

Renal Assessment/ Impairment

A blood sample must be taken at the time of catheterisation for Urea, Electrolytes and creatinine and arrangements made to ensure a result is received and acted on within 4 hours. If this is not possible in the community then the patient should be referred urgently to Emergency Department at BGH.

Patients with a creatinine rise of 20% or greater above their usual baseline level will require admission to Urology at BGH.

Rationale: Patients with evidence of renal impairment as a result of acute urinary retention are at risk of life threatening diuresis during the first 24 hours following catheterisation.

9. Infection

Antibiotic Prophylaxis

"Routine use of antimicrobial prophylaxis during catheter change should be avoided" (SIGN 88).

It is no longer the Policy in NHS Borders to cover patients with metal heart valves or with valvular heart disease with IV prophylactic antibiotic treatment prior to catheterisation. However any patient who has a urinary tract infection with pyrexia, and who requires catheterisation, should be assessed clinically and be prescribed the antibiotic treatment appropriate to their clinical need.

If episodes of sepsis are related to changes of catheter or the history of; consider antibiotic therapy in accordance with local guidelines and previous results.

Urinalysis

Urinalysis dip sticks must never be used to diagnose infection, or to initiate Catheter Specimen of Urine (CSU).

Diagnosis of infection and CSU for microbiology must always be based on clinical symptoms.

Lab Specimens

CSU should be sent to the lab in all circumstances where there are clinical signs of infection (CSU **must not** be sent based on urinalysis results alone).

Please refer to [Royal Marsden Manual](#) for guidance.

Potential signs and symptoms of urine infection

- supra-pubic pain
- loin pain (left or right)
- urgency
- bypassing of urine
- rigors
- new onset delirium
- fever greater than 37.9 or 1.5 C above base line on 2 occasions during 12 hours (SIGN 88)
- Sepsis of unknown origin
- 2 or more SIRS criteria.

NB A patient does not need to have all of these signs or symptoms to have a CAUTI

Use of antibiotics

Routine antibiotic therapy for patients with bacteriuria is not recommended as universal occurrence of bacteriuria after long periods of catheterisation is normal.

Where the patient is asymptomatic, antibiotics should be avoided in order to prevent the selection of resistant strains of colonising organisms.

Seek microbiological advice where specific clinical concern exists.

Treatment of CAUTI

Treatment of CAUTI must follow SIGN guidelines: <http://www.sign.ac.uk/pdf/qrg88.pdf> and [NHS Borders Joint Prescribing Formulary](#).

Please report any hospital acquired CAUTI on the local risk management system, Datix.

Immunosuppression

Patients with conditions resulting in a low white count or who are undergoing chemotherapy or are on other immunosuppressant medication may require a course of antibiotics following catheterisation. Seek advice from the Microbiologist.

Bladder instillations

Must not be used to prevent catheter associated infections (see guidance in Passport).

To minimise the risk of blockages and encrustations and catheter associated infections or patients with a long term indwelling urinary catheter:

- Develop a patient specific care regimen
- Consider approaches such as reviewing frequency of planned catheter changes and increasing fluid intake
- Document catheter blockages

10. Nurse Led Catheter Removal

What is Nurse Led Catheter Removal

The catheter must be removed as soon as clinically possible following insertion. Any delay in removal creates a significant risk of serious infection.

This is a simple nurse led tool used to assist and encourage early removal:

Does the patient have any of the following:

- Haematuria Visible?
- Obstruction –urinary?
- Urology surgery?
- Decubitus Ulcer – open sacral or perineal wound in an incontinent patient?
- Input/Output fluid monitoring?
- Not for resus/ comfort care/ physician required?
- Immobility due to physical constraints e.g. unstable fracture?

If NO: remove catheter

This tool is incorporated into the catheter passport which All patients with urinary catheter must have. This tool must be completed every day for inpatients and prior to each catheter change in the community.if all answers are NO the catheter must be removed.

Is medical approval required?

For all routinely catheterised patients medical approval is **NOT** required prior to removal by the Health Care Professional, subject to following this policy and indication for removal by assessment.

Where a medical or nursing concern exists discussion should be held with the multidisciplinary team prior to catheter removal.

11. Trial Without Catheter (TWOC)

Please refer to NHS Borders Nurse Led Catheter Removal tool (within passport) which will enable registered Health Care Professionals to initiate Trial without Catheter.

When to remove a catheter?

The catheter must be removed as soon as clinically possible following insertion. Any delay in removal creates a significant risk of serious infection.

Trial without catheter

The purpose of the TWOC is to assess the patient's ability to empty their bladder successfully following the removal of their indwelling urethral catheter. Any patient with a catheter must be reviewed regularly ([NICE Guidelines 2003](#)) and a planned TWOC must take place when an assessment indicates that it can be removed.

A clinical procedure must be followed in order to achieve optimum outcomes and to ensure that patient safety is maintained. A TWOC may fail and practitioners must be able to monitor and assess their patients for complications and manage these if they occur.

A TWOC procedure can be undertaken either in a clinical or home environment provided the practitioner has the appropriate knowledge and skills.

The most appropriate time for removing the catheter would be early morning, depending on clinical circumstances to ensure that the patient receives full support and monitoring during the day and that the voided urine can be measured. If the catheter is removed in the patient's home, the health professional must provide contact numbers in case problems occur and follow up visit within 4-6 hours must be planned with the patient to evaluate the trial.

It is important that the anticipated date for TWOC is documented in the NHS Borders Catheter Care Passport.

All patients undergoing a TWOC must have a NHS Borders Catheter Care Passport for accurate documentation, (unless the TWOC is part of a specific enhanced care pathway). If a patient is unable to void successfully an ongoing plan must be discussed and agreed with them. The bladder should be scanned using an ultrasound bladder scanner if there has been no void after 6 hours.

Trial Without Catheter Table (TWoC)

Post-operative Patients	Non Operative patients
<p>Catheter should be removed according to surgical advice (day 2) unless patients fall into one of the following categories;-</p> <ul style="list-style-type: none"> • Patient has had urological, gynaecological or perineal surgery or a procedure done entirely via laparoscope or has an approved post-operative care pathway • Written instruction by Surgeon indicates reason to continue catheterisation • Removal date or reason for continuation of urinary catheter must be documented on post-op day 1 or post-op day 2. If the TWOC fails a catheter passport must be started on insertion of the new catheter • The same criteria would apply for the approved post-op pathway in the event of a failed TWOC 	<p>Removal of catheter should be considered when;-</p> <ul style="list-style-type: none"> • Haematuria – visible? • Obstruction – urinary? • Urology surgery? • Decubitus Ulcer – open sacral or perineal wound in an incontinent patient? • Input/Output fluid monitoring? • Not for resus/Comfort care/Physician required? • Immobility due to physical constraints e.g. unstable fracture? <p>The TWOC for the above may be done in the community setting provided there is no record of difficulty with the initial insertion</p> <p>NB. Refer to 'Contraindications' section in this Policy</p>

Supra-pubic TWoC)

- If performing a supra-pubic trial, please attach a catheter valve for 24 – 48 hours before removing supra-pubic catheter
- Patient voids urethral and opens valve immediate post void and measures the drained volumes viw the catheter. If volumes drained are below 100mls please remove catheter
- Please contact Urology Specialist nurses for further advice.

ACTION:

- Remove catheter, document and measure Voided Volumes and Frequency
- Assess for voiding within 4-6 hours.
- If no voiding after 6 hours: bladder scan to measure bladder volume
- Scan shows <800 mls and no sensation reassess in 2 hours
- If scan shows > 800 re -catheterise or consider Intermittent Self-catheterisation
- If there is patient discomfort and an inability to void then re-catheterise or teach ISC (see ISC Protocol)
- Report TWOC outcome to referring clinician
- Document in Patient Catheter Care Passport

Responsibilities

Role	Responsibilities
Clinical Executive Operational Group	Formal Board approval of policy
General Manager/Clinical Lead	Will disseminate this policy to all clinical areas ensuring that processes are in place and that this policy is adhered to
Prevention of CAUTI Group	Will review documentation and education in support of this policy on a yearly basis
Ward/Departmental Managers	Will ensure that all staff are familiar with and follow this policy
Individual Clinical Staff	All clinical staff involved in urinary catheterisation will ensure they follow this policy

Implementation Plan

1. Professional responsibilities

a. Professional Leads/Partnership Forum/Public Representatives

- Disseminate the standards.

b. Clinical Governance Department

- Support compliance with the standards and support audit of compliance.

c. Clinical Executive

- Agree and sign off the standards.

d. Clinical Managers

- Implement the Policy into their area.
- Supervise compliance with the standards and organise audits as per the standards
- Respond to audit results and take corrective action when required.

e. Clinicians

- Ensure that their practice adheres to the standards.
- Participate in regular audit and engage in training and development as necessary.

2. Review

- The Prevention of CAUTI Group with public involvement will review the standards two years after issue or following any change in National Standards
- The results of Clinical Audits will be used to inform this review.

Appendix 1 - Protocol for Males presenting with Acute Retention of Urine

Urinary retention is a sudden and painful inability to pass urine, which is relieved by bladder drainage with either a urethral or supra-pubic catheter.

Acute Urinary Retention Initial Action

- Complete Patient Catheter Passport
- Follow advice on pyrexia prior to catheterisation (see Guide Line 2)
- Relieve retention by urethral catheterisation using a size 16 all silicone catheter. If there is difficulty with catheterisation contact the Urology Registrar on call
- Check and record observations. If the temperature is 38c or above arrange admission.
- Record time of catheterisation
- Measure and document the volume of urine drained up to 15 minutes post catheterisation (retention volume)
- Check urea, creatinine and electrolytes and send as an urgent request. A contact phone number should be included on the request form so that abnormal results may be reported promptly (within 4 hours of catheterisation) and admission arranged where necessary. (See Guideline 1)
- If clinical suspicion of infection, send CSU and start Trimethoprim
- Neither PSA or DRE necessary at this time

A retention volume of less than 500mls may indicate something other than acute urinary retention.

Consider other diagnoses. (E.g. neurological bladder dysfunction, UTI) and discuss with Surgical Registrar on call or OOH GP.

If retention volume between 500ml and 1000mls and: -

1. Renal chemistry is within normal range
2. Patient is over 40 years old
3. Catheter Care can be managed at home.

Admission is not required.

Discharge and supply with:

1. 2 week supply of alphablockade e.g. tamsulosin
2. Patient Information Book
3. Starter Pack
4. District Nurse Letter/Taycare.

If any of the following:

- Retention volume is over 1000mls
- Renal chemistry is impaired
- Patient is unable to manage at home
- Patient is under 40yrs
- Temperature 38°C or above.

Discuss with Surgical Registrar on call to arrange admission. Follow up will be decided on discharge.

FOLLOW UP PLAN (A/E & OOH)

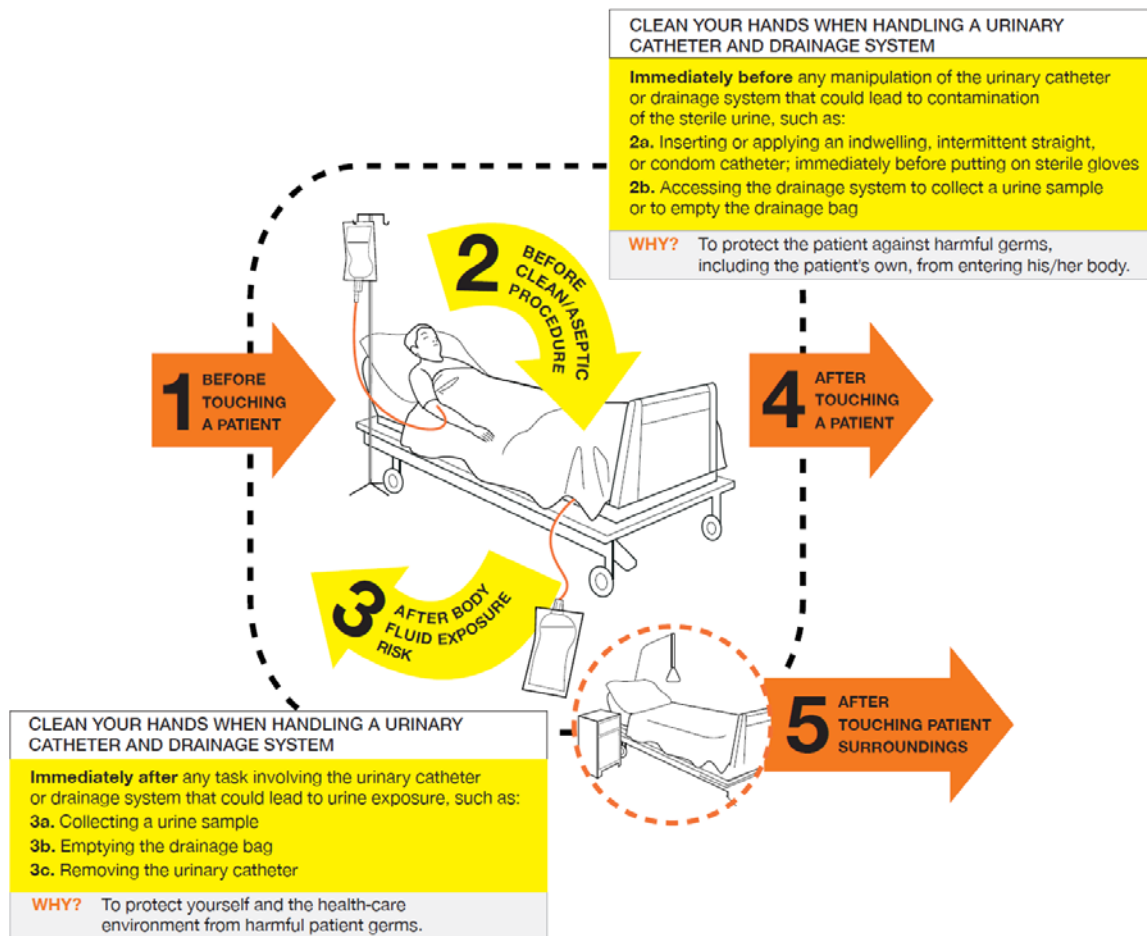
1. Complete Patient Passport or Taycare and place in Urology Nurse Specialist folder in A/E. at BGH
2. Urology Nurse Specialists will review folder daily and access results. An appointment for TWOC (trial without catheter) will be arranged for 1-2 weeks post catheterisation unless otherwise specified.

- If TWOC is successful the alpha-blocker should be continued and a prostate assessment clinic appointment arranged with the Nurse Specialist where uroflometry, IPSS, DRE and PSA will be monitored and further management decided
- If TWOC is unsuccessful then a consultant clinic appointment will be arranged within the next 6 weeks where PSA and DRE will be monitored and further decision made
- For patients under 40 years old, a Urology Consultant review appointment within 4 – 6 weeks is required whatever the outcome of the TWOC.

APPENDIX 2 – 5 moments for Hand Hygiene – Caring for a patient with a Urinary Catheter

My 5 Moments for Hand Hygiene

Focus on caring for a patient with a Urinary Catheter



- 5 KEY ADDITIONAL CONSIDERATIONS FOR A PATIENT WITH A URINARY CATHETER**
- Make sure that there is an appropriate indication for the indwelling urinary catheter.
 - Use a closed urinary drainage system, and keep it closed.
 - Insert the catheter aseptically using sterile gloves.
 - Assess the patient at least daily to determine whether the catheter is still necessary.
 - Patients with indwelling urinary catheters do not need antibiotics (including for asymptomatic bacteriuria), unless they have a documented infection.


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